MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, April 25, 2002*
10:07 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
BEATRICE S. BRAUN, M.D.
AUTRY O.V. "PETE" DeBUSK
ALLEN FEEZOR
FLOYD D. LOOP, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
JANET G. NEWPORT
CAROL RAPHAEL
ALICE ROSENBLATT
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

NOTE: Additional commentary from April 26 Meeting begins on page 15.

AGENDA ITEM: Payment for non-physician practitioners -- Craig Lisk, Marian Lowe

MR. LISK: Good morning. At the last meeting we discussed the first draft of this report on Medicare payment to non-physician providers and came away with some general ideas for what direction you wanted to go in terms of recommendations and conclusions. We've incorporated those into this draft of the report, which we'd like you to review.

At this meeting we need you to approve the current draft report, and also to vote on -- we have currently one recommendation in that report, and vote on that recommendation and discuss those.

As you can see here, though, from the slide, we have a change in the report title to help us separate the report that Marian was just discussing. Because this report is really basically looking at advanced practice nurses and physician assistants, we've titled the report Medicare payment for advanced practice nurses and physician assistants, although we are not looking at nurse anesthetists in this report, who is the other category of advanced practice nurses.

So that is what we were planning to do, but if you want to change back for some reason we can do that. We thought that the type of providers we're talking about in these reports were different so we wanted to indicate it with different report titles.

To briefly review the Congressional mandate, the Congress mandate requires the Commission study the appropriateness of the current payment rates for four different non-physician practitioners, certified nurse midwives, nurse practitioners, clinical nurse specialists, and physician assistants.

As part of the study, the Commission was also required to examine whether orthopedic physician assistants also should be paid separately, and whether current payment rates for these and other non-physician practitioners would be appropriate. Again, this study is due in June of this year.

I think the report contains information on who each of these providers are and what they do. I'm not going to go back over that again.

What I do want to go to next is to just briefly describe the payment rules governing these providers. We

basically have three type of issues that we're going to be looking at here, direct reimbursement, incident-to billing, and the issue of payment for the OPAs.

Under direct reimbursement, certified nurse midwives are paid at 65 percent of the physician fee schedule for services that they independently bill. In contrast, nurse practitioners, clinical nurse specialists, and physician assistants are paid at 85 percent of the physician fee schedule.

Part of the reason that this probably came about, in terms of lower reimbursement for nurse midwives, was that the BBA expanded payment for these other practitioners, there was more restrictions on their reimbursement and the settings and locations where they could be directly reimbursed. And nurse midwives did not face those same restrictions. They could independently bill in all different settings for the services they provided previously. That's one of the reasons the BBA expanded payment for the nurse practitioners, clinical nurse specialists, and physician assistants.

The other payment that is of issue is incident-to billing. Here, the supervising physician is paid at 100 percent of the physician fee schedule for services provided by these non-physician practitioners in an office or clinic setting. Incident-to billing does not apply to the hospital inpatient or outpatient settings. And incident-to rules require that the supervising physician be in the office suite and immediately available for consultation in order to bill incident to.

The physician must also have provided direct and personal and professional services to initiate the treatment of that patient. So if the patient is coming in with a new diagnosis, in order to bill incident to, the physician must see the patient in those cases. Otherwise, if the physician doesn't see the patient, then the nurse practitioner would bill at the nurse practitioner rate or the same case applies to a new patient, as well.

On incident-to billing, though, the physician is not required to see the patient alone very visit. Unfortunately, we don't have any indication of the amount of incident-to billing that goes on, because there's no indication on the Medicare bills to that. You'd have to go to the patient record in order to look at that.

Finally, on OPAs, OPAs are not reimbursed for their services by Medicare, in terms of direct billing of their services.

One other consideration on the incident-to billing is that there is higher reimbursement than when these other non-physician providers provide those services. One of the issues that does come up with incident-to billing that you had mentioned is the tension or pressure that that puts on the nurse practitioner or those other non-physician practitioners for the practice to bill at the higher reimbursement rate.

I think that's one of the concerns that the nurse practitioners have with incident-to billing, is that the pressure that they are under to bill at 100 percent versus 85 percent when, in fact, maybe in their eyes, the case does not meet incident-to services. And in that case, the physician's involvement may be very minimal in some cases. So that's one of the issues that has been brought up that I just wanted to mention to you.

The next slide provides our analytic approach that we had on the direct reimbursement. Basically, if the inputs used to provide non-physician practitioner services are the same as physician services, we might conclude that there should be no payment differential.

But if, however, we conclude that they are different we need to look at what is different. We looked at work, practice expense, and professional liability insurance. Within the work component, we see that there is difference in terms of the input to the education and potential perceived value of that education to the patient that the longer physician education may have.

We also know that in professional liability insurance there are large differences in malpractice insurance rates between non-physician practitioners and physicians, although for certified nurse midwives, their professional liability insurance is much higher than other non-physician practitioners professional liability insurance. In fact, their professional liability is equivalent to other internists or even, in some cases, higher than internists and family practitioners.

The next slide, in terms of from your discussion, we came to this recommendation for conclusion on the direct reimbursement. The text is a little bit changed from what you have in your report because we have to have an actor on here. So the recommendation reads the Congress should increase Medicare payment rates to certified nurse midwives to 85 percent of the physician fee schedule. The conversion factor for physician services should be adjusted so that the change is budget neutral.

You talked, at the last meeting, about any changes we made here should be done budget neutral, and we have dealt with that.

The amount of services that nurse practitioners provide is so small that the amount of change would be essentially trivial. It would be at the fourth decimal place in the conversion factor, so it's a very small change. In effect, because if you raise the rate you may have a little bit less incident-to billing, it may actually not cost anything, depending upon how it was scored. I just wanted to bring up that point.

So with that, I'd like to discuss this and then we'll move on to the incident-to discussion and conclusion on that.

DR. STOWERS: I just had a minor point. When you said that their professional liability was more than a family physician or internist, is that a family physician that's doing obstetrical care?

MR. LISK: No, that would be --

DR. STOWERS: I think we need to be real careful here because it's an apples and oranges kind of comparison.

MR. LISK: What I had indicated in the text is -- well, I had said gynecologists and I can put in there family physicians who do not provide obstetrics care.

DR. STOWERS: Because I just want to make sure that we're not comparing the lowest category of services done by a family physician to a family physician.

MR. LISK: No, these are all physicians who are not providing OB services.

DR. STOWERS: Which is kind of still an apples and oranges thing to me.

MR. LISK: But if you're looking at the portion or type of services that are being provided, in terms of evaluation and management...

MR. HACKBARTH: Any other comments on the recommendation? Do you want to go ahead and vote on this? Or do you want to talk about the other pieces?

MR. LISK: You might as well go and vote on this. The others are going to be conclusions, rather than recommendations.

MR. HACKBARTH: Okay. All opposed to this recommendation raise your hand?

All in favor?

Abstain?

Okay.

MR. LISK: As we discussed on incident to, there's

a discussion in the chapter on incident-to billing. Basically, this is a summary of the conclusion that we have in the report is that services provided by non-physician practitioners that are billed incident to should continue to be reimbursed at 100 percent of the physician fee schedule.

That comes, again, from your previous discussion. If that seems to be okay, but if you have any comments and discussion, now is the time to --

DR. WAKEFIELD: It's a little bit on this point. At what point could I make a few comments about the text, Glenn? Would now be the time, or can I just reserve my right? I'm a little bit on this one, but I want to make some other contextual comments.

MR. HACKBARTH: Why don't we stay on this one right now, Mary, but we can come back.

MR. SMITH: Craig, can I take you back to something that you said in passing, that some of these providers have institutional pressure to bill at 100 percent, regardless of the actual involvement of the physician, whether or not she's onsite or not.

If the world works the way it's supposed to work, the recommendation makes perfectly good sense. If the world doesn't work the way it's supposed to work, then without any knowledge but a healthy degree of skepticism that it works that way, I'm concerned about the sort of invitation to deceit, but I would solve it by going to 100 percent in both cases, rather than current law. It seems to me that the principle that ought to guide here, assuming that clinical integrity is maintained, is that the same service ought to be reimbursed at the same rate and that the artifice here that results in the 15 percent differential is not very convincing.

You raised it, I suspect we don't know very much, but what we do know would help me out, to the extent we know anything.

MR. LISK: I think some of that is the discussion -- you had a lot of that discussion actually at the last meeting where you were conceptually appealing to pay 100 percent for the services but there were some for the services, and that brings that even on the incident to, as paying the same regardless.

I think you had a lot of discussion. I think that's why we put in the paper, in terms of the text, that it was conceptually appealing to pay the same for those services, and we probably could put something in the text at that point regarding incident to, but then there's these

other issues about what incentives does that create for providers and who they use or the incentives for people to pursue a physician education, and people's potential perceived values of the physician services compared to a non-physician practitioners services, because of that additional education, may have some additional value. That's the rationale where we came to the previous recommendation, which was focused on the certified nurse midwives.

I don't know, that's a large part of the discussion you folks should have.

MR. SMITH: I'm not sure I found the incentive to pursue a medical degree, as opposed to a PA, not very convincing. To the extent that that incentive works, and to the extent that it's entirely financial, it has to do with all of the things that none of the non-physician practitioners can do anyway. In the instance where we're talking about the same service, it seems to me you're right, it's conceptually appealing, but we also ought to act to remove the incentive to distort and remove the pressure that you said some of the nurse practitioners raised, being encouraged to bill as if something happened that didn't.

MR. HACKBARTH: I just want to pick up on David's point. The discussion on the top of page 18, which lays out potential problems with paying the same amount for the non-physician practitioners as for physicians, to me felt a little bit strained. I think, consistent with the logic of the RBRVS system, there's really only one acceptable rationale for paying different, and that's if they're offering a different service. In everything else, it's just sort of make weight arguments.

Similarly, with the incident to, the only reason you would pay 100 percent there is it's a different product that you're buying with the physician's supervision. And there are admittedly problems in assuring that, in fact, there is physician supervision involvement that makes it a different product. But that's the only acceptable rationale for having differential payments.

I think all of the other stuff muddies the waters, as opposed to strengthening the argument.

DR. REISCHAUER: Glenn preempted me. When I read through this I thought, between the lines, 85 percent was about right for one group, but the incident to should probably be about 95 percent. And it's really because it's a different service and the different service might just be the insurance value of having the doc somewhere in the

vicinity for this. But I can live with our conclusion, in large measure because we seem to have not a lot of knowledge about what's going on.

I was wondering if we could include a statement that says it would be nice if we collected some information on how much of certain things are incident to, as opposed to being provided by the physician. Maybe we will discover that 97 percent of these activities are incident to, and then you might rethink the relative value scale, I would think, on some of this stuff.

DR. NELSON: I just want to point out that direct supervision also means that the physician is accepting responsibility for what happens, and if things go wrong in the middle of the night, presumably he or she is the one that gets the phone call. So it is a different service with respect to the incident two portion. It involves the responsibility clearly being assigned to the physician.

MR. DeBUSK: My question is to Ray, is to his thoughts on this, because this is something you deal with on a daily basis, right?

DR. STOWERS: I just would echo what Alan says, it's definitely a different service with that responsibility being there and the after hour call, the liability. There is so much importance put on the requirement of incident service to those first visit where the diagnosis is established. It is required under this, the medication is set up. There's a lot of difference in the original planning and diagnosis and care planning that takes care than what usually happens in these where you're monitoring them the diabetes or the blood sugar or whatever.

You can't just look at one follow up visit here, because incident-to service with the initial requirement of evaluation and treatment makes it more of a team approach and obviously both parties here are a part of that team. But it's not the same package. That follow up visit is not the same service when it's being supervised and working together as a team.

I think what we're paying for here is the team approach of having the two work together. And I think throughout Medicare we need to be paying for that team approach and I think the incident to is one way that that's occurring.

So I think to drop this to 85 or go the other way around, and I look at this as part of the 85 versus 100, as we're going to discuss later, we're going to have to decide in Medicare whether we're going to pay for this kind of

collaboration and working together to increase the quality of care.

In our place, that's the way we make it work and it does work the way it's supposed to with being in the building and working together and talking on the difficult cases and consulting with each other takes time and effort out of a practice to do that, and I think it ought to be compensated.

So I think it ought to stay at the 100 percent, just like it is.

DR. WAKEFIELD: A couple of comments. One on David's comment earlier. I thought in the text also it was interesting that we've got text that talks about the fact that -- to take a quote out of the text -- those who employ physicians and non-physician providers would likely have a far greater incentive to higher the lower cost provider if the reimbursement received was the same.

It seems to me that historically we have tried to allow the market to determine who was or what was the most qualified, cost-effective provider. That almost, that text almost takes me to the point where I'm thinking we're building in a market advantage for a type of provider. So that was my take on that language. I didn't feel comfortable with that particular piece of language.

The second point I wanted to make is on the incident two piece of this, I'm okay with this conclusion but I would say that I don't think that we've got -- well, two points. One, in terms of whether or not the care is the same or different, I think a lot of us would recognize nuances and differences of care and maybe clear some types of differences.

But right now, a nurse practitioner who's looking at an elderly patient with an ear problem is going to be held to the same standard of care that a physician does or a family practice doc does in the legal system, and that an ENT doc is held to. That standard of care is the same.

We can talk about differences in that service delivery. I don't see anything in the literature, but somebody else might, that speaks to any kind of different outcomes when these different providers are providing the same set of services, whatever that set of services is.

So the standard of care, which I think is about the only thing I can have that's sort of objective out there, doesn't vary based on who's providing that service. And if they're providing the service, they're all licensed to provide that service or they're going to be in a lot of

trouble when they try to claim reimbursement or anything else for having provided the service. That's just a second comment.

A third, on the 100 percent of the physician fee schedule, I think that Bob's recommendation is probably a good one. I do think there's value to the fact that there is a team there to provide services. But it's a little bit odd to me to put somebody inside of a building, a bricks and mortar of a building, a physician, or put them outside of it. And the service that's provided by that nurse practitioners, that service where it may only be that NP for example, seeing that patient on that given day and the next two or three subsequent visits, the payment can be the same depending on if you're paying through incident to or you're paying a direct reimbursement at 85 percent.

So I think there's value at having access to a physician. I would be clueless whether that value is 92 percent or 87 or 99. I don't think we know. So we're sort of coming in behind something for which there doesn't seem to be much data. We're also talking about differences in practice by different practitioners for which I don't know of any outcomes that would illustrate that. But I do know about standards of care that are equally applied to different providers.

So those are some points. And I'm concerned about how some of this reads in the text. So I'm not disagreeing with what we have up here, but I would have some of these perspectives that I'd really want to have you consider when we're looking at the text, which do not follow this logic.

And the education piece, the last point on this, I'm a little concerned about where -- I think it's fine to identify differences in education. I'm still looking at patient outcomes where we can and services delivered. But if we look at education, and all of a sudden we're going to build a lot of our rationale -- which is the way this text to me currently reads -- around education, we are now introducing a new factor, in a way, that wasn't part of the initial development of RBRVS where different types of physicians, for example, were not provided with different payment amounts except when you're providing a higher complexity of care in which case, and rightly so, that orthopedic surgeon is paid at a higher rate for providing a more complex piece of care than his or her family practice counterpart.

And that's where I think those distinctions ought to be drawn. Thanks. And so different concerns about the

text, from my perspective, on some of those issues.

MR. HACKBARTH: That was one of the concerns that I had is that I don't think the rationale can turn on educational differences without us getting sort of crosswise with the basic theory of RBRVS. So it needs to be characterized as a difference in product as opposed to difference in education.

As someone who's used a lot of nurse practitioner and physician assistant services personally, I think that the quality of service, at least in my personal experience, has been great. This is a bit of a dilemma for me. Certainly for the services that I've used, I don't see any discernible difference between the non-physician practitioner and an M.D.

But again, if we go back to the logic of RBRVS, if you say it's the exact same product, I think that leads you to the conclusion that you level down to the level of -- the payment would go down for physicians to the level of the non-physician practitioners, as opposed to saying well everybody ought to be pulled up to the M.D. level. Then that gets into a whole another set of problems.

That's a place that I'm not prepared to go based on the available information and data.

MR. LISK: What I was trying to convey in the text though is some of that discussion you had last time. What I'd like to know is what is the product difference that you would identify for a difference? That's what I was trying to convey is the potential value of that education is what may be providing a difference service, in terms of the value of education and the experience that goes into that is part of it. And then those other incentives that did come up in some of your discussion, because a lot of the discussion at the last meeting was leaning to coming to the conclusion of not paying different. But you came down to a vote that came down to basically maintaining a differential, based on some other discussion that occurred about some of the incentives that had occurred, and also some of this in terms of the value of the physician education.

Not saying that we're talking about the economic return to the physician's education, but the value of the physician providing that service versus the NP service and what the education might bring to that individual service, is what we're trying to convey.

I'd like a response back in terms of how people feel on that.

MR. HACKBARTH: I understand the challenge that

you face in writing it. I'm not sure that the best way to handle this specific wording is to try to write the language here. But your point is well taken, we need to be very careful about the language when we review the draft.

MR. FEEZOR: Just we've got enough swamps that I don't want to make another one, but I think we are on the edge, if we're not already, of probably needing to put some study or some future study around the term incident to, given current technologies and communication and telemedicine and even robotics. I think that's something we're going to have to probably come back and visit within the next year or two.

MR. HACKBARTH: A couple more minutes then we need to move on.

DR. WAKEFIELD: Actually that's a good point, Allen, especially when you look at how services are provided in rural areas or with rural health clinics, for example, and the designations of who you must have onsite and who you don't, but who you must have access to at distance and how you transcend that distance using technology, et cetera. I think you raise a very good point and I hadn't thought about that much before.

In terms of your comment, Craig, about the text, I just think it's worth looking at. From my perspective, there's no data in this text that said to me that when these providers give comparable services there's any difference in the work. The studies that were cited say, in fact, outcomes seem to be about the same.

So I don't know why we go down that road very far, as the text is currently configured. I can see your point, where you're trying to capture some of the dialogue from the last go round, but I think some of those areas, especially when we get very far into anything beyond saying there's a difference in education, I think is fraught with problems.

So I would be looking at that very carefully in terms of what conclusions are drawn that aren't supported by evidence in the text. In fact, the evidence in the text may take somebody to a little bit different conclusion, based on the studies cited.

MR. SMITH: Glenn, I'll try to be very brief. I think the text can't enter the issue of level up, level down. I agree with that and I think the paragraph, Craig, in the middle of page 18 needs to be rewritten to reflect it.

But just to comment on it, Glenn, again the 100

percent was supposed to be the cost of providing the service. Not the cost of getting educated to provide the service, not the appropriate economic return to the investment in education. So if there's an argument for leveling, it has to be a leveling up argument.

We're not ready to reach that yet, but we certainly shouldn't conclude, based on this conversation, what we appear to conclude in the text.

I agree with the recommendation, as I said earlier.

DR. NEWHOUSE: David, that's actually not -- we've said the opposite with our SGR discussion. We've said SGR delinks 100 percent from the cost of services. So we can't really argue that 100 percent is the cost of services.

MR. SMITH: Right, but we have argued that there is an appropriate payment for the service. Whether or not the current SGR system gets us there is a different issue.

DR. NEWHOUSE: But it may be 90 percent, it may be 110 percent.

MR. SMITH: But the difference is not -- we will not determine whether it's 90 or 100 or 105 by discriminating among the providers of the service. We need to get the price of the service right, and then we ought not to discriminate among those who provide it.

DR. NEWHOUSE: Yes.

MR. HACKBARTH: Okay, I think we need to move on here. For the two conclusions, we're just going to leave those as conclusions, no votes required on those?

MR. LISK: Yes. The conclusion on the orthopedic assistants, in terms of the last slide here, is that orthopedic physician assistants should not be recognized for separate reimbursement. Some of that is similar to conclusions when we're talking about the surgical technologists who serve as first assistants, is that there is very limited recognition at the state level of licensing of these folks, even though they may be providing very valuable services to patients.

MR. HACKBARTH: Here we'd be talking about them acting independently --

MR. LISK: Acting independently.

MR. HACKBARTH: -- where I think lack of state oversight is a bigger issue.

DR. LOOP: I'm somewhat sympathetic to the plight of OPAs. I think that if the state certifies OPAs then they should pay at 85 percent, because they add a lot of value to orthopedic practices. They're just hanging out there by

themselves.

I think that if they're really certified and there are some uniform training standards, then we should pay them.

MR. HACKBARTH: Other comments on OPAs?

MR. LISK: Did you want to pursue that as a recommendation or you're just bringing that up, Floyd?

DR. LOOP: There's not a lot of data on, except for your statement in the text, there's not any information on OPAs. I mean, it's a scattered group.

MR. HACKBARTH: Refresh my recollection, it's what, two states that currently --

MR. LISK: There's a few states that have some form of recognition. Tennessee, I think, is the one that has broader -- California recognizes those that graduated from programs in California. So in that narrow window that there were certified programs, California recognizes those. And in New York, they recognize them as first assistants at surgery. But that's the extent of it.

There used to be some recognition in Minnesota as well, but I don't believe that's current.

MR. HACKBARTH: So, Floyd, are you asking for us to consider a recommendation that in those particular jurisdictions, or in states that do recognize OPAs, that Medicare pay for them?

DR. LOOP: If they're recognized, they're certified by the state, then I believe that they should be paid. Do you want to say certified or licensed?

MR. LISK: Certified is national. They have a national certifying exam. But then, the state level is licensure for the other practitioners.

DR. NEWHOUSE: I'm worried about the consistency of what we did before. I mean, there were a number of licensed mental health practitioners that we just said we didn't think should be paid. So what is the argument for paying here?

DR. LOOP: Joe, I don't have a good answer. The mental health area is a little more diffuse. This is fairly easy to quantify what they do. That would be my answer.

DR. REISCHAUER: Am I right that these assistants don't have bachelor's degrees even, or the equivalent of a bachelor's degree necessarily?

MR. LISK: It varies.

DR. REISCHAUER: And they have no formal training program.

MR. LISK: Currently there is no formal schools

that provide it. It's an apprenticeship model to be able to get the training for new folks. It's an apprenticeship model, working with an orthopedic surgeon for five years, I believe, that has to be certified by that orthopedic surgeon.

The other route are people who are physician assistants or nurse practitioners. They will, of course, get reimbursed who can be recognized as an OPA. But basically the other training mechanism is through apprenticeship model with an orthopedic surgeon.

DR. REISCHAUER: I'd be very hesitant to move forward to classify these individuals as professionals who can get separately reimbursed.

MR. DeBUSK: Looking at the history of the orthopedic physician's assistant or however you want to classify this, there were schools, then there wasn't schools. Then apparently the American Academy of Orthopedic Surgeons took a different stand on that profession. And now it appears, from what I'm hearing, that they want to get back into it.

I think if they're going to move forward with this type of assistant in the future, which is very beneficial, the specialty training is certainly there, perhaps I'm asking you if the Academy of Orthopedic Surgeons came back with a plan or something that led to this certification or licensing, as Floyd addressed there, perhaps this is something that we could consider in the future, if that came together, right?

DR. REISCHAUER: Absolutely.

MR. HACKBARTH: Okay, so we'll leave it at that. I think that's it for you, Craig. Thank you very much.

April 26 Proceedings - discussion continued:

MR. SMITH: After yesterday's meeting Mary and Craig and I talked a little bit about the wording of the section which deals with the 85 percent payment for non-incident-to services. I'd like to spend a couple minutes at some point just making sure we're all on the same page about the way that language is framed in the text. The language in the text I don't think reflects yesterday's discussion and Craig would like a little more guidance and we ought to make sure we know what we're saying.

MR. HACKBARTH: Why don't we do that right at the front end? Can we just defer you for one moment, Sally? So

we need Craig up here.

MR. SMITH: The text in question is the first full paragraph on page 4 of Tab C. When we talked yesterday, and Glenn, you and I had a little conversation where we both agreed it seemed to me, and it seemed to me the Commission agreed, that there was no justification for a differential in payment for the same service. It wasn't clear whether the appropriate step was to level up or level down. We clearly didn't reach that decision.

But it did seem to me that what we ought to say here is rather than, there's a justification for the 85 percent, we're not sure that 85 percent for the same service provided by a non-physician practitioner is the right answer. We are clear that there's no justification to pay nurse midwives less, and they ought to get the 85 percent, and the subject of 100 or 85 deserves further consideration.

The text at the moment is conclusive on that. I don't think we are.

MR. HACKBARTH: My own perspective on that, David, was that we were conclusive on there being a difference. The point that I made was that there were several different arguments, potential justifications presented for why 85 versus 100. And the point I made was that in keeping with the overall logic of the RBRVS system, the only really consistent justification would be the product is different.

DR. NELSON: Right, it might be 75 percent.

MR. HACKBARTH: Can we specify, quantify exactly what that difference is? No. We have not reviewed the evidence on that and we haven't delved into it in that detail. But my own view was that, yes, it is a different product.

MR. SMITH: It may be a different product, but our conversation yesterday continued the March meeting where we expressed some confusion about whether or not it was a different product. At the moment we're defining the product as the same, and in keeping with our policy and good practice it would seem to me to that extent we ought to be paying the same fee.

But we're clearly not ready, I don't think, to reach the question of whether or not the product is different because it's provided by a different clinician. So rather than be conclusive in this paragraph it seems to me we ought to be neutral or open. It doesn't change the recommendation. It doesn't commit us to new policy. But it also doesn't conclude that in a case where we're defining the service as the same, the differential is justified,

which is the way the current language reads.

DR. ROSS: Can we just add language to the effect, at issue is whether in fact the service or the product is the same, and just lay out the possibilities for the difference?

MR. SMITH: I would think we could do something -- I think we ought to reiterate our belief that the same service ought to be similarly compensated and that there is a question of whether or not this is the same service and that deserves further examination.

Mary, would that --

DR. WAKEFIELD: Yes. I think the issue is, at least from my perspective, we don't have -- in responding to Congress we ought to making some comment, I would think, about the payment rates, because that seems to me what we're being asked to respond to. Yet we didn't come to a consensus about that 85 percent payment rate. There were different perspectives about it.

So it seems to me we ought to at least be neutral on that at this point and open up the possibility, or allow the possibility that it ought to be informed by further study or further analysis or whatever, which doesn't change any of our recommendations. It's just how are we, what are we saying about that 85 percent? Right now I think what we're saying in text there's not general agreement about.

So that being the case, could there be a caveat inserted there that is somehow neutral on that part of the issue? Unless you don't feel compelled to be responsive to Congress on that piece, but it seems to me that's what they're asking for. So I don't know how you dodge that bullet, frankly.

So it's not changing recommendations or conclusions. It's the approach to that discussion that I think we're talking about.

DR. STOWERS: I'm okay with reframing that as long as we open or leave open the debate of whether the service is the same or not. I don't think we should make that decision at this point either.

MR. SMITH: Right. I think that reflects our ambivalence and uncertainty about whether or not the service is the same. It would be inappropriate to conclude that it is the same at the moment, given the concerns Alan and Ray raised yesterday. So we ought to be open rather than close it. The current language says, we concluded. I think that is inappropriate.

MR. HACKBARTH: Does it seem like there's

agreement? Okay, we'll modify the language in the text.
Thank you, Craig. You did a great job there.